Pine Valley Central School District

ANNUAL HEALTH INFORMATION UPDATE SCHOOL Year 2020-2021

TO BE COMPLETED BY **PARENT / GUARDIAN** AND RETURNED TO PVCS SCHOOL NURSE ASAP

Student's Name_____ Grade _____

Please complete the following checklist and give details below (attach any additional pertinent information).

Does the student currently or had in the past year, any of the following conditions?

	YES	NO
Allergies (seasonal, food, environmental, medication, insect)		
Behavioral issues		
Contagious illness/infectious illness		
Anemia (include Sickle Cell)		
Arthritis (rheumatoid conditions, scleroderma)		
Asthma (give details below)		
Back / Neck Injury		
Bladder / Kidney Disease		
Bleeding / Clotting Disorder		
Cancer		
Chickenpox		
Convulsions or Seizures		
Diabetes or Hypoglycemia [low blood sugar]		
Head Injury (Concussion/ loss of consciousness)		
Hearing Loss/Correction & Evaluation		

	YES	NO
Headaches/Migraines		
Heart Condition or treatment		
Hepatitis		
High Blood Pressure]		
Learning Difficulties (ADD/ADHD/other)		
Mononucleosis or other viral illness		
Orthopedic (skeletal injury, treatment, surgery)		
Psychiatric or psychological issues & treatment		
1. anxiety, depression		
2. psychosis		
Surgery		
Speech Evaluation and Therapy		
Vision Impairment or correction		
Weight related issues (eating disorder, obesity)		
Other		

Please give details and dates to all of the above marked ***YES***. _____

_____

- Is the student currently under any kind of **medical care or treatment**? _____YES_____ NO

Explain_____

- Is the student taking any **medication** on a regular basis (prescription or non-prescription)? ____YES ___ NO

List the medication, dose, times and reasons for taking. _____

_____

Contact the school nurse to make arrangements for any meds to be given in school.

Has the student received the following immunizations or boosters since last reporting to school?
Please provide dates below & follow-up with written documentation from your physician.
Meningitis: _____ Gardasil Series_____

Date of last Physical exam _____Physician _____Phone_____

Date of last Dental exam _____ Dentist _____Phone_____

Health Insurance (Name of company) _____

Social Security Number_____

Describe any **modifications or restrictions** that are needed to accommodate your child's health or safety._____

Is there any other information that you would like the nurse to know? _____

Parent/Guardian Signature: _____

Your signature authorizes nurse to share health information with school staff on a "need to know" basis.

When you have a concern or new information related to your child's health or safety, please call or email

Elementary School Nurse Mrs. Bukoskey at (716) 988-3291 ext.: 3325 {kbukoskey@pval.org} or
Jr. /Sr. High School Nurse Mrs. Kenney at (716) 988-3276 ext: 4324{jkenney@pval.org}.